SOCOG TRAINING SCHEDULE 2024

Check the trainings for which you would like to register
and return with registration form and payment.

Medication Administration Refresher 9 am - 11 am
**Current Medication Certification is required for everyone taking this course*

Annual Provider Training 11 am - 5:30 pm

- ☐ **August 27**
- ☐ **November 26**

Medication Administration Refresher - Only	$ 40.00
Annual Provider Training	$100.00
Annual Provider w/Med Admin Refresher	$110.00

Medication Administration Training Cost: $140
**Current Provider Certification is required for everyone taking this course*

- ☐ **August 14-15** 9 am - 5:30 pm
- ☐ **November 13-14** 9 am - 5:30 pm

First Aid/CPR Cost: $65

- ☐ **August 2** 9 am - 2 pm
- ☐ **November 1** 9 am - 2 pm

Insulin Injection Refresher Cost: $30

- ☐ **September 5** 11 am - 12 pm

Other available trainings scheduled as requested. Minimum two students required.

G-Tube Training Cost: $60
Insulin Injection Cost: $60
G-Tube Training Refresher Cost: $30

SOCOG TRAINING REGISTRATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

County of employment: _____

☐ New Provider

☐ Current Provider working on license renewal

☐ License Expired, seeking renewal

☐ I would like to speak to Provider Compliance Specialist as I have questions about my certification requirements.

Method of payment:

☐ **Check made out to SOCOG**
Mail with this registration form to SOCOG, PO BOX 456, Chillicothe OH 45601

☐ **Drop off cash or check to SOCOG**
167 W Main Street, Chillicothe OH 45601

☐ **Pay online at www.socog.org.** Form is not required with online registration. Information will be collected online.

**Medication Administration form is required for everyone taking the Medication Administration Refresher or 2-Day Medication Administration Course. This form is required by the State of Ohio and must be completed before you will be registered to the course.The form can be returned with this registration packet or emailed to providersupport@socog.org.*

Ohio Department of Developmental Disabilities

Application for DD Personnel to Attend the DODD Medication Administration (MA) Certification Course

Prior to DODD Medication Administration Certification (Initial Certification class or Renewal): DD Personnel must submit a completed application to the RN Trainer, including all Employer and Personal information and signatures. DD Personnel whose application forms are not completed or without required signatures are not eligible for DODD Medication Administration certification.

DD Personnel: (print)_____

PAGE 1: MUST BE FULLY COMPLETED BY EMPLOYER **Date of Application:** _____

Agency Employer? ☐ **OR** **DODD Certified Independent Provider?** ☐

If you are a DODD Certified Independent Provider, for purposes of this application, you are the employer.

EMPLOYER:_____ **DODD PROVIDER NUMBER:** _____

WORK LOCATION: At the time of this application, where does this person primarily provide services or supervision?

☐ **At the address listed above OR**

☐ **Other agency location - Address:** _____

_____

Work Location Phone: _____ **E-mail:**_____

(If no direct phone or e-mail at location, list DD employer agency phone and e-mail

SUPERVISOR: At the time of this application, who is the direct supervisor of this DD personnel?

Print Name & Title of direct supervisor: _____

_____

Phone for direct supervisor: _____ **E-mail for direct supervisor:** _____

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When did this supervisor begin supervision of this DD personnel? Date: _____

Please verify all of the following are true as of the date of this application:

- **This person is employed by the agency** ☐ **YES** **Start Date:** _____
- **This person at least 18 years of age:** ☐ **YES**
- **The agency has been provided documented proof of this person's high school diploma or equivalency?** ☐ **YES**
- **All background check requirements have been completed according to OAC 5123:2-2-02 including results and registry checks within the specified time frames** ☐ **YES**

As the agency employer of the DD personnel whose name appears on this application, I attest that all information provided on this application is accurate and current.

Print _____

Name & Title of Agency Employer/Designee

_____ **Date:** _____

Signature of Agency Employer/Designee

Ohio Department of Developmental Disabilities
Application for DD Personnel Medication Administration Certification

PAGE 2: MUST BE COMPLETED BY DD PERSONNEL

Prior to attending a DODD MA Certification Course: DD Personnel are required to complete this application, including all information and signatures. Without a completed application DD Personnel will not be eligible for DODD Medication Administration certification to administer medications.

This Application is for:

Category 1- Medication Administration ☐ **Category 2- G/J Tube Medications** ☐ **Category 3 - Insulin** ☐

Category 1 Renewal ☐ **Category 2 Renewal** ☐ **Category 3 Renewal** ☐

Have you ever taken a medication administration certification class before this application? ☐ **YES** ☐ **NO**

PRINT: Last Name _____

First Name _____ **Middle Initial:** _____

***Last four* digits of social security number:** ___ ___ ___ ___ (not full number)

Date of Birth: __ __/__ __/ __ __ **Gender:** ☐ **Female** ☐ **Male**

Are you an Independent Provider? ☐ **YES** ☐ **NO** **If yes, do you have:**

☐ **High School Diploma or** ☐ **High School Equivalency Document** **(must provide proof to RN Trainer)**

Personal Address: _____

City: _____ **State:** _____

Zip: _____ **County:** _____

Home: (____)_____ **Work :**(____)_____ **Cell :**(____)_____

Personal E-mail: _____

Your certificates and renewal notices will be sent to you by e-mail.
You MUST provide an e-mail address where you will reliably receive messages.

At the time of this application, do you work for more than one DD employer? ☐ **YES** ☐ **NO**
If YES please print the names and Provider Number of all DD employers you currently work for:

DD Employer: _____ **Provider #** _____

DD Employer: _____ **Provider #** _____

I attest that all information provided on this application is true, current, and correct.

_____ **Date:** _____
Signature of DD Personnel

RN TRAINER should keep this application in a retrievable file, which is accessible to authorized personnel and DODD upon request for at least 7 years

_____
RN Trainer Signature (includes validation of HSD/GED for Independent Providers) **Date**

_____
Session # (If Initial Certification – not renewal)